

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula Gen HospHow long in hospital or institution? 1 hr 10 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County SussexCity or town Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Arvey, Lawrence Edward

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1/10/1942

8.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

655

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH

June 3 1948 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3 1948 to June 3 1948
and that I last saw him alive on June 3 1948

Immediate cause of death

Acute tonsillitis
Acute laryngitis
with edema of larynx

DURATION

4 days

Died to

Bilateral lymph
adenitis, cervical
(Include pregnancy within 3 months of death)4 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. V. Soller M.D.
Delmar, Md.

M. D. or other

Address Delmar, Md. Date signed 6-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Penmonk General Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Worcester
 City or town Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War #1 ✓

3. (a) FULL NAME

Bagnell, Mr. John

3. (b) Social Security Number

217-09-3784

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Stella Bagnell
 7. Birth date of deceased (mo., day, yr.) February 5, 1895
 8. AGE: Years 53 Months 4 Days 25 If less than one day hrs. min.

9. Birthplace Blayton, Accomack, Virginia
(Town, county, and state)10. Usual occupation Delmar Lumber Co11. Industry or business Saw Trimmer12. Name Charlie Bagnell13. Birthplace Virginia14. Maiden name Emma Annie15. Birthplace Virginia16. Informant Mrs. Stella BagnellAddress Pocomoke city, Md.17. Burial Date thereof July 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BethanyLocation Pocomoke city, Md.18. Funeral director Henry H. WatsonAddress Pocomoke city, Md.19. July 3 19 48 Southeaston Taylor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 48 at 11:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 19 48 to June 30 19 48and that I last saw him alive on June 30 19 48Immediate cause of death Cerebral Thrombosis DURATION 24 hrs.

(Hemiplegia)

Due to Cerebral Arteriosclerosis SymptomDue to Coronary Artery Heart 2 yrs.Other conditions disease

(Include pregnancy within 3 months of death)

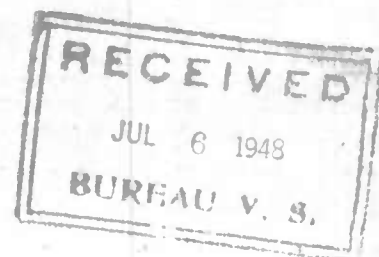
Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE David L. Groves M.D. M. D. or other —Address Salisbury, Md. Date signed June 30, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6603

Reg. Dist. No. 939

1. PLACE OF DEATH:

County... Wicomico
City or town... Silviam
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yrs
Hospital, institution, or street address where death occurred:
Silviam Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... Wicomico
City or town... Silviam
(If outside city or town limits, write RURAL and give nearest town)
Street No... Silviam
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Katie Bounds

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Isaac J. Bounds
7. Birth date of deceased (mo., day, yr.) July 1, 1884 6.(c) If alive, give age 66 years
8. AGE: Years 62 Months 11 Days 7 If less than one day
hrs. min.

9. Birthplace... Silviam, Wicomico, Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Washington Taylor

13. Birthplace Silviam Md

14. Maiden name Margaret Anne Sugrue

15. Birthplace Silviam, Md

16. Informant Mrs. James Pearson

Address Silviam, Md

17. Burial (Burial, cremation, or removal, which) Burial Date thereof 6/11/48
month (day) (year)

Cemetery or crematory Silviam church

Location Silviam, Md

18. Funeral director The Bell & Johnson Co

Address Talbot, Md

19. 6/11, 1948 Registrar Harriet L. Johnson
(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6.8.48 19... at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3.1 19... to 6.8 19...
and that I last saw h... alive on 19...
Immediate cause of death 5.30.48

Chronic hepatitis
Due to chronic cholecystitis
cholangitis
Due to cholangitis

Other conditions

(Include pregnancy within 5 months of death)

Major findings at operations chronic cholecystitis
cholangitis Date of op 3.4.48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harriet L. Johnson M. D. or other

Address 405 N. Division St Date signed 6.10.48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:

County.....*Wicomico*
 City or town.....*Pineville*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*Life*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*MD* County.....*Wicomico*
 City or town.....*Pineville*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Martha Martin Bradley

3. (b) Social Security Number

4. Sex.....*F.* 5. Color or race.....*W.* 6.(a) Single, married, widowed, or divorced.....*Widowed*

6.(b) Name of husband or wife.....*John Bradley*

7. Birth date of deceased (mo., day, yr.)

Nov. 4, 1859

B. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*88**7**21*

.....hrs.min.

9. Birthplace.....

Pineville, Wicomico, MD.
(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date there.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

*6-26-48**1948**Valley Manor*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 24, 1948 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1944 to *June 24, 1948*
 and that I last saw him alive on *June 24, 1948*

Immediate cause of death.....

Chronic Myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

Chronic Nephritis

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

William E. Smith

M. D. or other

Address.....*Hebron, MD* Date signed.....*June 25-48*

STAMP TO IDENTIFY TRAINING

STAGE 10-5 TRAINING

RECEIVED

JUN 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Somerset Wicomico
City or town Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name was

3. (a) FULL NAME

Glenn Butler

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Martha Butler

6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1872

8. AGE: Years 76 Months 6 Days 1 If less than one day

9. Birthplace East Princess Anne, Somerset, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Truck Farming

12. Name Levin Butler

13. Birthplace Princess Anne, Md.

14. Maiden name Priscilla Townsend

15. Birthplace Princess Anne, Md.

16. Informant Mrs. Martha Butler

Address Princess Anne, Md. R.F. D#2

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 20, 1948
(month) (day) (year)

Cemetery or crematory Oliver Cemetery

Location East Princess Anne, Md.

18. Funeral director Nate Daskell

Address Princess Anne, Md.

19. 6/17/48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th 1948 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/5/48 to 6/17/48

and that I last saw him/her alive on 6/16/48

Immediate cause of death Lobar Pneumonia DURATION 5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Tubercular peritonitis Date of op. 6/11/48

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public places (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver G. Fowler M. D. or other

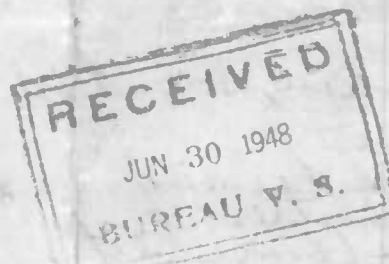
Address Salesbury, Md. Date signed 6/17/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Gram

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6606

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Reg. Dist. No. 332

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred
223. East Isabelle St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 223. East Isabelle St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Nancy Jane Calloway

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Charles E. Calloway

7. Birth date of

deceased (mo., day, yr.)

Nov. 20, 1862

6. (c) If alive, give age

Dead

8. AGE:

8578

It less than one day

hrs.

min.

9. Birthplace

Surry County Delaware
(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

at home

FATHER

12. Name

Painter Elliott

13. Birthplace

Surry County Delaware

MOTHER

14. Maiden name

Mary Hall

15. Birthplace

PO Ocean City Maryland

16. Informant

Mr. Sydney E. Calloway

Address

223. East Isabelle St. Salisbury MD

17. (Burial, cremation, or removal) Which?

Burial

Date thereof

June 30-48
(month) (day) (year)

Cemetery or crematory

Parsons Cem.

Location

Salisbury Maryland

18. Funeral director

W. H. Holloway & C. O. Martin R. Holloway

Address

Salisbury Maryland

19. Date rec'd by registrar

June 30 - 1948 Southeaston Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1948 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1948 to June 27 1948and that I last saw him alive on June 26 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

arteriosclerosis

Due to

hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE

L. P. Grammel M.D. M. D. or other

Address

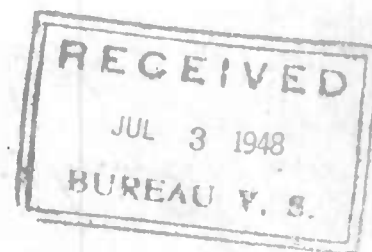
Salisbury, Md. Date signed 6/29/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 993

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 735 W. Satellite St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Carey Miss. Bonnie

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 20, 18848. AGE: Years 63 Months 5 Days 27 It less than one day
.....hrs.min.9. Birthplace Allen, Wicomico Md
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Washington Carey13. Birthplace Allen, Md14. Maiden name Anna Bourde15. Birthplace Allen, Md16. Informant Mrs Jessie R. CantrellAddress Salisbury, Md17. Burial Date thereof 6/19/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allen ChurchLocation Allen, Md18. Funeral director The Bell & Johnson CoAddress Salisbury, Md19. 6/19 1948 Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 1948 at 6 p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical to death and that I last saw him alive on 6-16 1948Immediate cause of death Fractured femur Left

DURATION

18 days

Due to

Due to

Other conditions Cardiovascular
Renal disease
(Include pregnancy within 3 months of death)Major findings of operations None

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of May 31, 1948Where did injury occur? Salisbury Wicomico Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fell on carpet Injured at work? No23. SIGNATURE Salisbury, Md M. D. or otherAddress Salisbury, Md Date signed 6/16/48

RECEIVED

JUN 30 1948

BUREAU V. S.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6608

FILE No. G 116 JUL 9 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula Gen Hosp.
How long in hospital or institution? 1 hr. 8 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Norcut
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Carter, Mr. Theodore Nelson

3. (b) Social Security Number

4. Sex male 5. Color of race W 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Mary S Carter
6. (c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) Dec. 7, 1891
8. AGE: Years 56 Months 6 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)
10. Usual occupation Pharmacist
11. Industry or business Carter's Drug Store
12. Name Theodore W. Carter
13. Birthplace Cartertown Pa.
14. Maiden name Rena Louise Nelson
15. Birthplace Philadelphia Pa.

16. Informant Mr. Ernest Holland
Address Berlin, Md.
17. Buried Date thereof 6/12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Chester Rural
Location Chester Pa.
18. Funeral director Anna H. Burbock
Address Berlin Md.

19. 6/11 19 48 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 48 at 11 p. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 19 48 to June 9 19 48
and that I last saw him alive on June 9 19 48
Immediate cause of death Myocardial Insufficiency DURATION 6 mo.
Due to Arteriosclerosis 22 yrs.
Due to Heart Disease
Coronary Artery
Sclerosis & Thrombosis 2 yrs.
Other conditions _____
(Include pregnancy within 3 months of death)

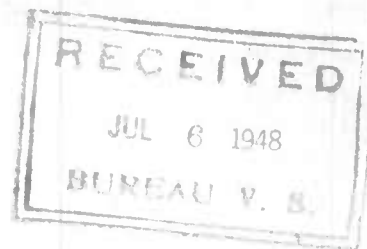
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE David Gilmore M.D. M.D. or other _____
Address Salisbury Md. Date signed June 10, 1948

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6609

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula Gen. Hosp.
How long in hospital or institution? 1 day 9 hrs. 31 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Farmington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Cathie Baby Girl

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 31 - 1948

8. AGE:

Years

Months

Days

It less than one day

10 hrs. 10 min.

9. Birthplace

Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

Cathie Willard

13. Birthplace

Upper Farmington Md.

14. Maiden name

Lord Dorothy Elizabeth

15. Birthplace

Farmington Md.

16. Informant

Address

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

June 3, 1948
(month) (day) (year)

Cemetery or crematory

Peninsula General Hospital

Location

Salisbury, Maryland

18. Funeral director

Address

Salisbury, Md.19. 6/5/48

(Date rec'd by registrar)

19 4819 4819 48

23. SIGNATURE

Address

124 E. Main St.

M. D. or other

Date signed 6/2/48

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-219 48 at 6:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____
and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

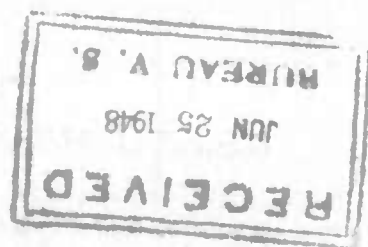
Address

124 E. Main St.

M. D. or other

Date signed 6/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. Age is especially important. Physicians: please write the causes of death clearly and fully.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Passaic Nursing Home (Salmon Road)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. PO #2 (Marble Road)
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Charles Linwood Chandler

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Clara Chandler
7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1873 6. (c) If alive, give age Dead years
8. AGE: Years 75 Months 4 Days 5 If less than one day
.....hrs.min.

9. Birthplace North Hampton Co. Virginia
(Town, county, and state)

10. Usual occupation Trucking (Motor Truck)

11. Industry or Business Trucking (Motor Truck)

12. Name Charles Chandler

13. Birthplace North Hampton Co. Va.

14. Maiden name Unknown

15. Birthplace Virginia

16. Informant M. Stanley Chandler

Address PO #2, Marble Rd. Salisbury Md.

17. Burial, cremation, or removal (Which?) Buried Date thereof June 22 - 1948
(month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Maryland

18. Funeral director Holloway, G. Walter R. Holloway

Address Salisbury Md.

19. Date rec'd by registrar 6/22/48 Registrar Wassie L. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1948, at 550 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948, to June 18 1948
and that I last saw him alive on June 18 1948

Immediate cause of death Brain metastasis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury

23. SIGNATURE Frederic P. Gamble MD M. D. or other
Address Salisbury, Md. Date signed 6/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 30 1948

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICAL CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

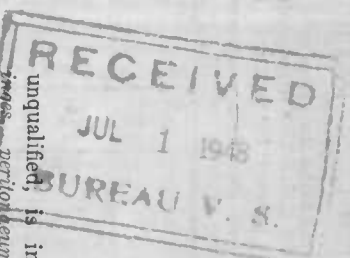
1 PLACE OF DEATH County <u>Wicomico</u> <u>Peninsula General Hospital</u> Village or City <u>Salisbury</u> (No. _____) St. _____ Ward _____			STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>332</u>		
2 FULL NAME <u>Sarah Ellen Clark</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>S</u>	16 DATE OF DEATH <u>June 29, 1948</u> (Month) <u>29</u> (Day) <u>48</u> (Year) <u>48</u>		
6 DATE OF BIRTH <u>April 7, 1941</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased <u>from</u> <u>June 29, 1948</u> to <u>June 29, 1948</u> , 19 <u>48</u> that I last saw her <u>dead</u> on <u>June 29, 1948</u> , 19 <u>48</u> and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows:		
7 AGE <u>7</u> yrs. <u>2</u> mos. <u>22</u> ds. or _____ min.?			If LESS than 1 day _____ hrs.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Schoolgirl</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			Shock following Crushing infarct of abdomen (Duration) _____ yrs. _____ mos. _____ ds.		
9 BIRTHPLACE (State or country) <u>Ocean City, Maryland</u>			Contributory Accident: <u>6/27/48 - 10:35 AM</u> Secondary (Home) <u>Struck by auto truck</u> Driveway (Duration) _____ yrs. _____ mos. _____ ds.		
10 NAME OF FATHER <u>James Wm. Clark</u>			(Signed) <u>N. E. [Signature]</u> M. D. <u>6/30/1948</u> (Address) <u>Medical Examiner</u> <u>Wicomico City, Md.</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
12 MAIDEN NAME OF MOTHER <u>Edith Hudson</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients & Recent Residents)		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Wm. Clark</u> (Address) <u>West Ocean City, Md.</u>					
15 Filed <u>June 29, 1948</u> <u>Souise Strong Taylor</u> Registrar					
19 PLACE OF BURIAL OR REMOVAL <u>Md.</u>			DATE OF BURIAL <u>July 1, 1948</u>		
20 UNDERTAKER <u>Mrs. Anna A. Burbage</u>			ADDRESS <u>Berlin, Md.</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archdeacon, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (o) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"



unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6612

94a

Reg. Dist. No. 333

1. PLACE OF DEATH:

County McCombs
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
210 Elizabeth street.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)
 State MD County McCombs
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 210 Elizabeth street.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

James Henry Colbert

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Nellie Blithant Colbert

7. Birth date of deceased (mo., day, yr.) April 20-1895 8. (c) If alive, give age 47 years

8. AGE: Years 53 Months 1 Days 14 If less than one day
 ...hrs. ...min.

9. Birthplace Stanford Conn.
 Town, county, and state

10. Usual occupation Truck Driver

11. Industry or business for Coastal Bank Lines

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Nellie Blithant Colbert

Address Rochester New York

17. Burial Buried Date thereof June 10-48
 (Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory mt Hope Cem.

Location Rochester New York

18. Funeral director William & Co. Mallett & Co. Salisbury Maryland.

19. 6/7/48 19 48 Registrar Harriet L. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6th 19 48 at 3:52 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical and that I last saw him alive on 6/6/48

Immediate cause of death Coronary blood disease

Due to sudden death

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

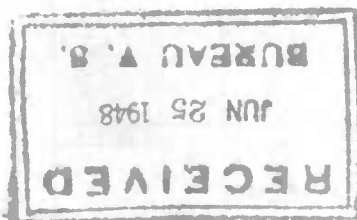
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ed. H. Hester M.D. or other

Address Salisbury Md. Date signed 6/7/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 383

6613

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 204 Fourth
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Ellen Jones Collier

3. (b) Social Security Number

no

4. Sex FEMALE 5. Color or race aa 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife J. John Collier

7. Birth date of deceased (mo., day, yr.) 1873 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

70 hrs. min.

9. Birthplace Salisbury, Wicomico Co., Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Jacob Jones

13. Birthplace Salisbury Maryland

14. Maiden name Sallie White

15. Birthplace near Salisbury Maryland

16. Informant Mrs. Martha C. Estwick

Address 703 - W. 180th N.Y.C. N.Y.

17. Burial Date thereof June 4 - 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Houston Cemetery

Location Salisbury Maryland

18. Funeral director James F. Stewart

Address 402 E. Church St. Salisbury Md.

19. 6/4/48 Registrar James F. Stewart
 (Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 19 48 at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 19 48 to June 1 19 48

and that I last saw her alive on June 1 19 48

Immediate cause of death Cerebral Thrombosis DURATION 8 days

Due to Atherosclerosis Indef.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. O. Farrell, M.D. M. D. or other

Address 800 W. Main St. Salisbury Md. Date signed 6-4-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

6614

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? One year three mo.
 Hospital, institution, or street address where death occurred:
103 Second no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 103 Second
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Frank Washburn

3. (b) Social Security Number

no

4. Sex

male

5. Color or race

aa

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Martha Washburn

7. Birth date of deceased (mo., day, yr.)

1878

6. (c) If alive, give age years

1878

8. AGE:

70

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Quantico md
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

same as above

MOTHER FATHER

12. Name

Peter Washburn

13. Birthplace

Quantico md

14. Maiden name

Emily

15. Birthplace

Quantico

16. Informant

Martha Washburn

Address

Salisbury md

17. Burial

BurialDate thereof July 4, 1948
(month) (day) (year)

Cemetery or crematory

Quantico md

Location

Quantico md

18. Funeral director

James Stewart

Address

Salisbury md

19. 7/4

(Date rec'd by registrar)

19. 48

Washburn

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 June 19 48 at 430 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
15 Jan 19 48 to 26 June 19 48
 and that I last saw him alive on 26 June 19 48

Immediate cause of death

Cerebral H. secondary age

DURATION

24 hours

Due to

Hypertensive Cerebrovascular Disease

Due to

Cardiovascular Disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert H. Samuels, M.D.

M. D. or other

Address

Date signed

28 June 48

RECEIVED

JUL 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6615

Reg. Dist. No. 332

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

11 years
15 days

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. Peninsula Drive
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Davidson Mrs. Dorothy

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Davidson Mr. Earl

7. Birth date of

deceased (mo., day, yr.)

March 6-1907

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

41321

hrs.

min.

9. Birthplace

Castle Colorado

(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

FATHER

12. Name

Charles Edward Heizer

13. Birthplace

Great Bend Kansas

MOTHER

14. Maiden name

Dorothy Winney Kendall

15. Birthplace

Philadelphia Pa.

16. Informant

Mr. Earl Davidson

Address

Peninsula Drive, Salisbury Md

17. Burial

(Burial, cremation, or removal. Which?)

Date interred

June 12-9-48

(month) (day) (year)

Cemetery or crematory

Greenbrow Cem.

Location

Greenbrow, Maryland

18. Funeral director

Hollings & G. Walter P. Hollings

Address

Salisbury Maryland

19. Date rec'd by registrar

June 28481948Lois Strong Taylor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 27th1948 at 12⁵⁰ p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 June1948to 27 June1948

and that I last saw him alive on

27 June 481948

Immediate cause of death

Cerebral edema

DURATION

Due to

Metabolic brain lesion

Due to

Brain-Papillary carcinoma

Other conditions

Extensive metastasis toliver, small & large intestines

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

No disease (died June 27 June 48).

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. Doney, M.D.

M. D. or other

Address

Peninsula Hosp. SalisburyDate signed June 27, 48

RECEIVED

JUN 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

6616

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula Gen. Hosp.
How long in hospital or institution? 1 day 18 hrs 56 min.

3. (a) FULL NAME

Farmer, Baby Boy

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 7-1948

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

9. Birthplace

P.B. Hight. Salisbury Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18.

Address

19.

(Date rec'd by Registrar)

19

48

Harris

L. Johnson

Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

Md.

County

Wicomico

City or town

Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.

124 Princeton Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 9

19

48

at

608

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/8

19

48

to

6/9

19

48

M

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

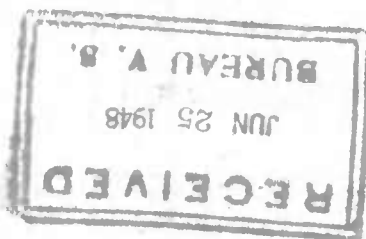
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH:

County Wicomico
 City or town Gesterville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Wicomico
 City or town Gesterville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Farrow, Jr.

3. (b) Social Security Number

243-30-0129

4. Sex

m

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

-

7. Birth date of deceased (mo., day, yr.)

Oct. 16, 1895

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

52717

hrs.

min.

9. Birthplace

Bedford, Maryland, Va.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

Charles Farrow

13. Birthplace

Bedford, Virginia

14. Maiden name

Rose M. Farrow

15. Birthplace

Bedford, Virginia

16. Informant

Martha Woodley

Address

Gesterville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6/5/48
(month) (day) (year)

Cemetery or crematory

Gesterville Colored Cem.

Location

Gesterville, Md.

18. Funeral director

Walter R. Holloman

Address

Salisbury, Md.

19.

(Date rec'd by registrar)

19 6/5 4819 48Walter R. HollomanReal

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 219 48at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 May19 47to 2 June19 48

and that I last saw him alive on

2 June19 48

Immediate cause of death

Cardiac Failure

DURATION

2 days

Due to

Acute Cardio-vascular

Due to

Disease with

Other conditions

Acute aneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic AneurysmAortic Aneurysm

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert H. Sanders MD

M. D. or other

Address

Salisbury, Md.Date signed June 5, 1948

RECEIVED

JUN 18 1948

BUREAU V. S.

Evidence for change of age and birth date shown on: MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

6618

FILE NO. G-116 JUL 13 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 857

1. PLACE OF DEATH:

County Wilcomica
City or town Hebron and
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One year
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County Wilcomica
City or town Hebron md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION) no
2.(a) If veteran, name war

3. (a) FULL NAME

Madeline b Furr

3. (b) Social Security Number

215-20-2581

4. Sex female 5. Color or race a.a. 6.(a) Single, married, widowed, or divorced married

(b) Name of husband or wife Carlton Furr
yes 6.(c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) May 6, 1923
Hebron, Md

8. AGE: Years 25 Months 12 Days 14 If less than one day hrs. min.

9. Birthplace Hebron
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business same as above

12. Name James Waters

13. Birthplace Antioke md

14. Maiden name Lee Della Waters

15. Birthplace Antioke md

16. Informant Carlton Furr

Address Hebron md

17. Burial Date thereof June 12, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Antioke

Location Antioke and

18. Funeral director James H. Stewart

Address Salisbury md

19. 6/12/48 19 48 Registrar George E. Johnson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 48 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 48 to June 10 19 48 and that I last saw her alive on June 10 19 48

Immediate cause of death Subcutaneous Hemorrhage DURATION 1 day

Due to Injury

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; Accident, suicide, or homicide Accident Date of 6-10-48

Where did injury occur? Hebron Wilcomica md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of Injury Accidental fall Injured at work?

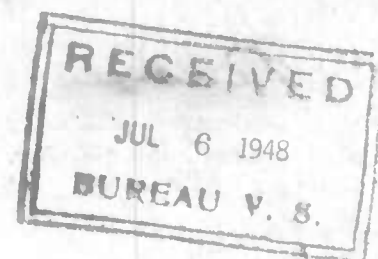
23. SIGNATURE E. A. Furrnell M.D. M. D. or other

Address 800 W. Main Date signed June 12, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6619

Reg. Dist. No. 332

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 4 days, 3 hours, 40 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Hebron
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lillie S. Gale

3. (b) Social Security Number

4. Sex

Female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Wilson Gale

7. Birth date of

deceased (mo., day, yr.)

July 28, 19026. (c) If alive, give age 51 years

8. AGE:

Years

Months

Days

If less than one day

45 10 28 hrs. min.9. Birthplace Quantico, Wicomico, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

Harrison Jackson12. Name Harrison Jackson13. Birthplace Quantico, Md.14. Maiden name Rachel Currier15. Birthplace Quantico, Md.16. Informant Wilson GaleAddress Hebron Md.17. Burial Date thereof 6/28/48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Parkview CemLocation Parkview Cem18. Funeral director David T. McGeeAddress Hebron Md.19. June 29 - 1948 Southern Maryland

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-48 at 9:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-21-48 to 6-23-48and that I last saw him alive on 6-25-48 at 48

Immediate cause of death

DURATION

Pericardial embolismDue to Pericardial embolismDue to Pericardial embolismOther conditions Chronic appendicitis

(Include pregnancy within 3 months of death)

Major findings of operations Retro-Plexion Uterus; Chr. AppendicitisRelaxed Perineum Date of op. 6-21-48

(7/14/48) OS.

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

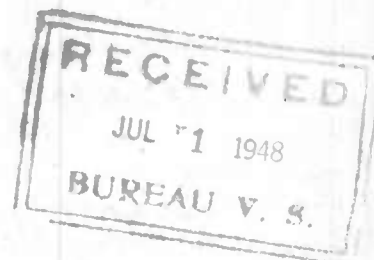
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Theresa A. Taylor M. D. or otherAddress Salisbury, Md. Date signed 6-28-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6620

Evidence for change of

age shown on:

FILM No. G 116 JUL 12 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yr

Hospital, institution, or street address where death occurred:

500 N. Division ST.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 500 N. Division ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cora Humphreys Hillis

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Harry Hillis6. (c) If alive, give age 53 years

7. Birth date of

deceased (mo., day, yr.)

July 25, 1895

8. AGE:

Years

Months

Days

If less than one day

522/3105

hrs.

min.

9. Birthplace

Rockaway, md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Alpheus Humphreys

13. Birthplace

Rockaway, md

MOTHER

14. Maiden name

Louella S. Tamm

15. Birthplace

Unknown

16. Informant

Mr. Harry Hillis

Address

500 N. Division ST

17. (Burial, cremation, or removal, which?)

Burial

Date thereof

6/10/48
(month) (day) (year)

Cemetery or crematory

Parsons

Location

Salisbury, md

18. Funeral director

The Hill & Johnson Co

Address

Salisbury, md

19. (Date rec'd by registrar)

6/10/48

19. (Date of death)

6/9/48

Registrar

23. SIGNATURE

Address

Robert R. Starr
M. D. or otherSalisburyDate signed 6-9-48

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 48 at 4:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 19 47, to June 8 19 48and that I last saw her alive on June 8 19 48

Immediate cause of death

Cerebral hemorrhage

Due to

Ruptured cerebral

Due to

artery

Other conditions

Invalid's disease

(Include pregnancy within 3 months of death)

Major findings of operations Gastrojejunostomyperformed Dec 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

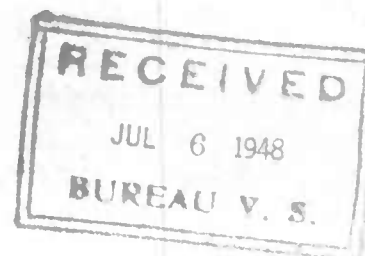
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert R. Starr

Salisbury

Date signed 6-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6621

137a

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 Days
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Accomack City Rural #2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2. (a) If veteran, name war 70 ✓

3. (a) FULL NAME

Sinn, James

3. (b) Social Security Number

None

4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Emma Jones
 7. Birth date of deceased (mo., day, yr.) March 1 - 1876
 8. AGE: Years 72 Months 3 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Stocketon, Wicomico, Md
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name George Sinn
 13. Birthplace Maryland
 14. Maiden name Estelle Sinder
 15. Birthplace Maryland

16. Informant Belle Roberts

Address Accomack City, Md Rural #2

17. Burial Date thereof June 9, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Georgetown

Location Accomack City, Md Rural #2

18. Funeral director Wm H. Hill, Md

Address Wm H. Hill, Md

19. 6/6-1948 Registrar Barrie E. Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1948 at 9:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1948 to June 2 1948

and that I last saw him alive on June 2 1948

Immediate cause of death acute Cardiac failure (Include pregnancy within 3 months of death)

Due to Chronic myocarditis

Due to _____

Other conditions Hypertrophy prostate

urinary retention

(Include pregnancy within 3 months of death)

Major findings of operations Prostate hypertrophy

of prostate Date of op. June 2, 1948

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

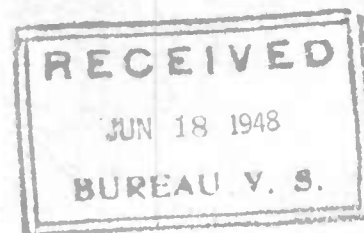
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Philip A. Sush M. D. or other _____

Address _____ Date signed _____



RECEIVED

JUN 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH:

County McComickCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Leroy Guthrie

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary E. Guthrie

7. Birth date of deceased (mo., day, yr.)

March 29-1896

8. (c) If alive, give age _____ years

53

8. AGE:

Years 52Months 2Days 2

If less than one day

hrs.

min.

9. Birthplace

Smymna Delaware
(Town, county, and state)

10. Usual occupation

Insurance Agent

11. Industry or business

FATHER

12. Name

Leonard Guthrie

13. Birthplace

Vienna Md.

MOTHER

14. Maiden name

Florence Vilghman

15. Birthplace

Smymna Del.

16. Informant

Mrs. Mary E. Guthrie

17. Burial

Frederick Md.

(Burial, cremation, or removal. Which?)

Date thereof

June 5-48
(month) (day) (year)

Cemetery or crematory

Parson Ave

Location

Salisbury Md.

18. Funeral director

Walter R. Johnson

Address

Salisbury Md.

19.

6/6-1948

Date recd by registrar

Barrett & Johnson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 3-48 at 12:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-3-1948 to 6-3-1948and that I last saw him alive on 6-3-1948

Immediate cause of death

Coronary Artery Disease

DURATION

Due to

Other conditions

Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul A. Smith

M. D. or other

Address

Salisbury Md.Date signed 6-5-48

RECEIVED

JUN 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:

County Wicomico
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Wicomico
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) if veteran, name war

3. (a) FULL NAME

Annie Stachia Harrington

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1855 6. (c) If alive, give age years

8. AGE: Years 92 Months 9 Days 13 If less than one day hrs. min.

9. Birthplace Nanticoke, Md.
(Town, county, and state)

10. Usual occupation at home

11. Industry or business Housework

12. Name Alfred Harrington

13. Birthplace Nanticoke, Md.

14. Maiden name Julia Benson

15. Birthplace Nanticoke, Md.

16. Informant Bernice Walter

Address Nanticoke, Md.

17. Burial Date thereof 6/8/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Turners Cemetery

Location Nanticoke, Md.

18. Funeral director Hillman & Co. Walter R. Hillman

Address Salisbury, Maryland.

19. 6/8/48 19. 48 Registrar

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 June 19. 48 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 February 19. 48 to 6 June 19. 48
and that I last saw him alive on 6 June 19. 48

Immediate cause of death Cardiac Failure DURATION 24 hours

Due to Arteriosclerotic Cardio-vascular disease
Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

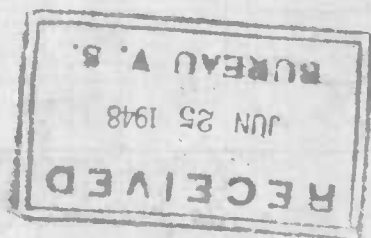
23. SIGNATURE Paul and H. Saunders M. D. or other

Address Nanticoke, Md. Date signed 7 June 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6624

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Accomac
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Annandale General HospitalHow long in hospital or institution? 12 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AccomacCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. Andrews Rd.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Hayward, Baby Boy

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 8, 1948 8. (c) If alive, give age 12 years8. AGE: Years Months Days It less than one day 12 hrs. 12 min.9. Birthplace Salisbury, Accomac, Maryland
(City, county, and state)

10. Usual occupation

11. Industry or business

12. Name Hayward, Robert13. Birthplace Salisbury, Md.14. Maiden name Baxter, Mary Refolda15. Birthplace Salisbury, Md.16. Informant Mrs. Thelma Baxter (grandmother)Address Salisbury, Md.17. Cremation Date thereof 6/8/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Annandale General HospitalLocation Salisbury, Md.18. Funeral director Annandale General HospitalAddress Salisbury, Md.19. 6/10/48 Registrar Barrie C. [illegible]

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1948 at 2:10 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw him alive on 19Immediate cause of death Hydrocephalusdist. feet / vert. possiblebut immediate cause congenital 10 min.Due to abnormalities

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

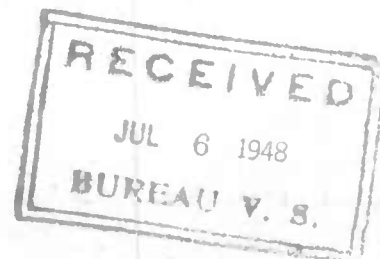
Means of injury Injured at work?

23. SIGNATURE Osborne Christensen M.D.Address Salisbury, Md.Date signed 6/8/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

County Harmon
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harmon

City or town Gettysburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hull, Baby Girl PHYLLIS YVONNE

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6-48

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

9 hrs. 43 min.

8. Birthplace

Salisbury, Harmon, Maryland
(town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden name

Hull Myrtle Elaine

15. Birthplace

Gettysburg, Md.

16. Informant

Benjamin Hull

Address

Gettysburg, Maryland

17. Burial, cremation, or removal. Which?

Cremation

Date thereof

6/29/48
(month) (day) (year)

Cemetery or crematory

Peninsula General Hospital

Location

Salisbury, Maryland

18. Funeral director

Peninsula General Hospital

Address

Salisbury, Maryland

19. Date rec'd by registrar

June 29 48

Loise Strong Taylor
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 48 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

28 June 48 19 48 to 28 June 19 48

and that I last saw him alive on 28 June 48 19 48

Immediate cause of death Cerebral aneurysm

DURATION

Due to

Cerebral Sphaler

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

the above (done 28 June 48)

Autopsy results the above (done 28 June 48)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

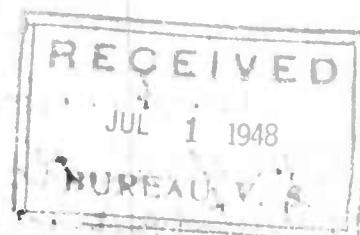
23. SIGNATURE

J. Strong, M.D.
Address Salisbury, Md. Date signed June 29, 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Percent correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Penninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Chalkeyville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jarman, Mr. William Leonard

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Jarman Mrs. Sadie7. Birth date of deceased (mo., day, yr.) Oct. 11, 1849 6.(c) If alive, give age _____ years8. AGE: Years 68 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Chalkeyville, Md.
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business _____

12. Name Leonard Jarman13. Birthplace md14. Maiden name Mary Jane15. Birthplace md16. Informant Sadie JarmanAddress Chalkeyville, Md.17. Burial, cremation, or removal, Which? Burial Date thereof 6/24/48
(month) (day) (year)Cemetery or crematory Chalkeyville, Md.Location Chalkeyville, Md.18. Funeral director M. Parker WatsonAddress Chalkeyville, Md.19. 6/23 1948 Registrar Passant J. Johnson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1948 at 8:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1948 to June 22 1948 and that I last saw him alive on 8:35 P.M. 1948Immediate cause of death BronchopneumoniaDue to Renal FailureDue to Cerebral Hemorrhage

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Cerebral Hemorrhage
obstructive lesion Date of op. June 17, 1948Autopsy results Ca. of Cerebrum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William B. Long M.D. (Long & Knicker)Address 504 N. DuPont St. M. D. or other _____Signed Salisbury, Md. Date signed June 22, 1948

RECEIVED

JUN 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6627

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred: none
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 307 E. Church St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

James L. Johnson

3. (b) Social Security Number

4. Sex male 5. Color or race aa 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife E. Wallace Johnson
 7. Birth date of deceased (mo., day, yr.) March - 1881
 6.(c) If alive, give age Don't know years

8. AGE: Years 67 Months — Days — If less than one day — hrs. — min. —

9. Birthplace Salisbury, Wicomico Co. Maryland
 (Town, county, and state)

10. Usual occupation Teacher - retired

11. Industry or business

12. Name Unknown
 13. Birthplace —

14. Maiden name Unknown
 15. Birthplace —

16. Informant Mrs. E. Wallace Johnson
 Address 307 E. Church St. Salisbury, Md.

17. Burial, cremation, or removal, Which? Burial Date thereof 6-22-48
 (month) (day) (year)
 Cemetery or crematory Houston

Location Salisbury Maryland
 18. Funeral director James H. Stewart
 Address 402 E. Church St. Salisbury Md.

19. 6/22/48 1948 Barrie E. Johnson Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1948 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 1948 to June 18 1948
 and that I last saw him alive on June 18 1948

Immediate cause of death

Arterio Sclerosis

DURATION

Not
known

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur M. Browne, M.D.
Salisbury, Md. Date signed 6/20/48

RECEIVED

JUN 30 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6628

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County ThamesCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ThamesCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Joyce Ann

3. (b) Social Security Number

Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 6-14-19488. AGE: Years _____ Months _____ Days 9 It less than one day 19 hrs. 25 min.9. Birthplace P.B. Hozit. Salby Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Herman F. Jones13. Birthplace Prinville Md.14. Maiden name Catherine P. Ponce15. Birthplace Prinville Md.16. Informant Mr. Herman F. JonesAddress Prinville Md.17. Burial, cremation, or removal, date thereof June 28-48
(month) (day) (year)Cemetery or crematory Mt. Pleasant Church Co.Location near Prinville Md.18. Funeral director Holloway & Co. Walter R. HollowayAddress Salby Md.19. 6/26/48 19 48 Registrar Barrett Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 48 at 8:45 A.M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from June 14 19 48 to June 23 19 48and that I last saw her alive on June 23 19 48Immediate cause of death Fistula procto-vesicalLeft facial paralyticDue to early developmentof facial-paralyticDue to region

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Injured at work? _____

23. SIGNATURE James R. MannAddress Salby Md. Date signed 6/23/48

M. D. or other _____

19 48 Registrar Barrett Johnson

(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 28 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

County WicomicoCity or town Lyaskin, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WicomicoCity or town Lyaskin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Martha Ellen Jones

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Irving Jones6.(c) If alive, give age 83 years

7. Birth date of

deceased (mo., day, yr.)

Sept. 17, 1971

8. AGE:

Years

76

Months

9

Days

5

If less than one day

hrs. min.

9. Birthplace

Fruitland, Wicomico, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Thomas Powell

13. Birthplace

Fruitland, Md.

14. Maiden name

Mary Ann Powell

15. Birthplace

Fruitland, Md.

16. Informant

Lloyd Larmore

Address

Lyaskin, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

6/24/48
(month) (day) (year)

Cemetery or crematory

St. Marys Episcopallen

Location

Lyaskin, Md.

18. Funeral director

Greenway & Co. Funeral Home

Address

Salisbury, Md.

19.

(Date rec'd by registrar)

19 48Lois Strong Taylor
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1948 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

13 June 1948, to 22 June 1948and that I last saw him/her alive on 20 June 1948

Immediate cause of death

Cerebral Thrombosis

DURATION

6 days

Due to

Arterio Sclerosis

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

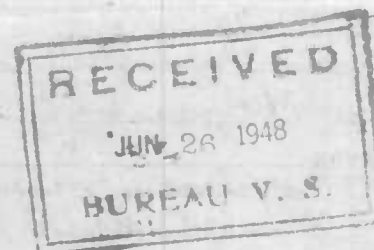
Injured at work?

23. SIGNATURE

M. D. or other

Address

Waverly, Md. Date signed 23 June 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH: **Wicomico**
 County **Salisbury**
 City or town **Salisbury**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **5 days - 1 hr - 25 min**
 Hospital, institution, or street address where death occurred:
Peninsula Gen Hosp
 How long in hospital or institution? **5 days - 1 hr - 25 min**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County **Somerset**
 City or town **Princess Anne**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

SADIE BEATRICE JONES

3. (b) Social Security Number

4. Sex **Female** 5. Color or race **Colored** 6. (a) Single, married, widowed, or divorced **Married**

6. (b) Name of husband or wife **Henry Jones**6. (c) If alive, give age **57** years7. Birth date of deceased (mo., day, yr.) **February 25, 1901**

8. AGE: Years **47** Months **3** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Princess Anne-Somerset-Md**
(Town, county, and state)10. Usual occupation **Cook**11. Industry or business **Domestic**12. Name **Augustus Wilson**13. Birthplace **Princess Anne, Md.**14. Maiden name **Susan Dennis**15. Birthplace **Princess Anne, Md.**16. Informant **Henry Jones**Address **Princess Anne, Md.**17. Burial **Burial** Date thereof **June 9, 1948**
(Month) (day) (year)Cemetery or crematory **Wesley Cemetery**Location **Princess Anne, Md.**18. Funeral director **H. Harvey Bradshaw**Address **Crisfield, Md.**19. **June 16, 1948**

Date filed by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **June 6, 1948** at **8:25 P**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I am now _____

Immediate cause of death **Chloride of Mercury****1st 2nd line**

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **suicide** Date of **6/29/48**Where did injury occur? **Princess Anne Somerset Md**

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **Home**Means of injury **Gun** Injured at work? **No**Signature **Wm. S. Sanford Sup.** M. D. or other **6/8/48**Address **Princess Anne Md** Date signed **6/8/48**

RECEIVED

JUL 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:

County... Wicomico
 City or town... Sharptown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... Wic
 City or town... Sharptown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lankford, Cyrus

3. (b) Social Security Number

213-16-8022

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

4. Sex M 5. Color or race White
 6. (a) Married 6. (b) Name of husband or wife... Grace Lankford

7. Birth date of deceased (mo., day, yr.) March 25 1900
 6. (c) If alive, give age 44 years

8. AGE: Years 48 Months 2 Days 20 If less than one day
 hrs. min.

9. Birthplace... Baltimore MD
 (Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

12. Name... Stalter Lankford13. Birthplace... MD14. Maiden name... Born E. Lankford15. Birthplace... MD16. Informant... Grace LankfordAddress... Sharptown17. Burial, cremation, or removal, Which? Date thereof 6. 18. 48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... St. MichaelsLocation... Sharptown18. Funeral director... Gravner BrosAddress... Sharptown

19. (Date rec'd by registrar) 19. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1948 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical and that I last saw him alive on June 15 1948

Immediate cause of death... Coronary heart disease

Due to...

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op. ...

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; No

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE... LaRadenburghAddress... LaRadenburgh Date signed 6/15/48

DURATION

acute

RECEIVED

JUN 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 899

PLACE OF DEATH:

County Wicomico
City or town Pasquotank
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Pasquotank
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.T.D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Henry Sayfield

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) June 19, 1948
6.(c) If alive, give age _____ years
8. AGE: Years _____ Months _____ Days 10 hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1948 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiner's Certificate and that I last saw him alive on _____ 19____

Immediate cause of death Infantile Convulsions DURATION 4 days
Epilepsy 5 days

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Thomas H. Sayfield Date 6/30/48
Address Pasquotank, Md.

9. Birthplace Pasquotank, Md.
(Town, county, and state)
10. Usual occupation _____
11. Industry or business _____
12. Name Walter Sayfield
13. Birthplace Seelma, Del.
14. Maiden name Dorothy Bender
15. Birthplace Pasquotank, Md.
16. Informant Walter Sayfield
Address Pasquotank, Md.
17. Burial, cremation, or removal. Which? Burial Date the body _____ 6-30-48
(month) (day) (year)
Cemetery or crematorium Sayfield
Location Seelma, Delaware
18. Funeral director W. S. Spaulding
Address Seelma, Del.
19. 6/30, 1948 Registrar Thomas H. Sayfield

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 6 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6633

Reg. Diat. No. 933

1. PLACE OF DEATH:

County Princess AnneCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Peninsula Gr. Hosp.How long in hospital or institution? 8 days 33 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)Street No. R.R. # 2

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

Mason, Mr. John

3. (b) Social Security Number

unk known

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife John M. Murray Mason6. (c) If alive, give age 37 years7. Birth date of deceased (mo., day, yr.) Feb. 17, 1896

8. AGE: Years Months Days If less than one day

52 3 28 hrs. min.9. Birthplace Mt Vernon, Somerset, Md.
(Town, county, and state)10. Usual occupation Waterman + Carpenter11. Industry or business Same12. Name George P. Mason13. Birthplace Mt Vernon, Md.14. Maiden name MaryAnna Scott15. Birthplace Mt Vernon, Md.16. Informant Mrs. Clara MasonAddress Princess Anne, Md.17. Burial (Burial, cremation, or removal, which?) Burial Date thereof June 18, 1948
(month) (day) (year)Cemetery or crematory Astbury CemeteryLocation Mt Vernon, Md.18. Funeral director W. Dale WashellAddress Princess Anne, Md.19. 6/16/48 19 48 6/15/48
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 48 at 8:18 P. M.21. CERTIFY that death occurred on the date above stated, that I attended deceased from June 8 19 48 to June 15 19 48and that I last saw him alive on June 15 19 48Immediate cause of death Mesenteric Thrombosiswith infarctionDue to arteriosclerosis,mesenteric & generalDue to Myocardial insufficiency 1 yr.Hypertensive Heart Disease 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David J. Gilmore M.D.Address Salisbury, Md. Date signed June 15, 1948

1896-3-28

22-2-17

2-45-
1948-8-12

RECEIVED
JUN 30 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

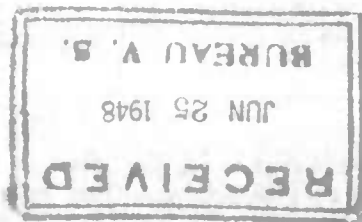
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6634

Reg. Dist. No. 233

1. PLACE OF DEATH County <u>Salisbury</u> City or town <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred <u>1912 N. Division, St.</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>MD.</u> County <u>Wicomico</u> City or town <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>1912 N.</u> <u>Division, St.</u> (If rural, give LOCATION) 2.(a) If veteran, name WAR			
3. (a) FULL NAME <u>Lucie Mae Nevitt</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>				5. Color or race <u>White</u>			
6. (a) Single, married, widowed, or divorced <u>Widow</u>				6. (b) Name of husband or wife <u>Robert L. Nevitt</u>			
7. Birth date of deceased (mo., day, yr.) <u>July 22-1888</u>				8. (c) If alive, give age <u>Dead</u>			
8. AGE: Years <u>59</u> Months <u>10</u> Days <u>15</u> If less than one day: hrs. min.				9. Birthplace <u>Dumfries, N. H.</u> (Town, county, and state)			
10. Usual occupation <u>at home</u>				11. Industry or business			
12. Name <u>William K. Jackson</u>				13. Birthplace <u>So. Hill Highland C. Va.</u>			
14. Maiden name <u>Georgianna Sipe</u>				15. Birthplace <u>Green Bank Va.</u>			
16. Informant <u>Mrs. Georgianna Jackson</u> <u>1912 N. Division St. Salisbury Md.</u> <u>Beard</u>				17. (Burial, cremation, or entombment, which?) <u>Beard</u> Date thereof <u>June 9, 1948</u> Cemetery or crematory <u>Beard</u> Location <u>Salisbury Maryland</u> 18. Funeral Director <u>William G. Walter R. Holloway</u> Address <u>Salisbury Maryland</u>			
19. (Date filed by registrar) <u>6/9/48</u>				20. DATE OF DEATH <u>June 7, 1948</u>			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>June 7, 1948</u> and that I last saw him alive on <u>June 7, 1948</u> Immediate cause of death <u>Cancer of Abdomen</u> Other conditions <u>None</u> (Include pregnancy within 9 months of death) Major findings of operations <u>None</u> Date of op. <u>Dec 1945</u> Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>None</u> Date of <u>June 7, 1948</u> Where did injury occur? <u>None</u> (City or town) (County) (State) Injured at home, farm, industry, public place (where?) <u>None</u> Means of injury <u>None</u> Injured at work? <u>None</u>				DURATION <u>10 4 1/2</u>			
23. SIGNATURE <u>Wm. K. Jackson</u> Address <u>Salisbury</u>				M. D. or other <u>Beard</u> Date signed <u>6/8/48</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6635

Reg. Dist. No. 339

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 612 W. Seaboard
 (If rural, give LOCATION)
 2(a) If veteran, name war no

3. (a) FULL NAME

Annie Mae Peters

3. (b) Social Security Number

213-14-6999

4. Sex Female 5. Color or race aa. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife James Wesley Peters
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 9-16-1890

8. AGE: Years 57 Months 9 Days 7 It less than one day hrs. min.

9. Birthplace Head-of-Creek, Wicomico Co., Md.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Same as above

12. Name Samuel Wilson

13. Birthplace Head-of-Creek, Wicomico Co., Md.

14. Maiden name Annie Jones

15. Birthplace Head-of-Creek, Wicomico Co., Md.

16. Informant Mrs. Madeline Perry

Address 580 Orange St., Newark, N. J.

17. Burial Date thereof 6-27-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Head of Creek

Location Head of Creek, Maryland

18. Funeral director James F. Stewart

Address 402 E. Church St., Salisbury, Md.

19. 6/26 19. 48 Barrie G. Johnson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19. 48 at no M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1948, to June 23 1948, and that I last saw her alive on June 23 1948

Immediate cause of death cardio-vascular-nephritic DURATION unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James R. Mann M. D. or other

Address Salisbury, Md. Date signed 6/26/48

RECEIVED

JUN 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

6636

1248

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospHow long in hospital or institution? 3 days, 6 hours, 10 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. 1
(If rural, give LOCATION)2(a) If veteran, name war no ✓

3. (a) FULL NAME

Purnell, Walter

3. (b) Social Security Number

no

4. Sex

male

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

no6. (c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.)

1885

8. AGE:

Years 63Months —Days —

If less than one day

hrs. — min. —

9. Birthplace

Taylorville md
(Town, county, and state)

10. Usual occupation

busk

11. Industry or business

same as above

12. Name

Albert Purnell

13. Birthplace

Taylorville md

14. Maiden name

Annie Mary Taylor

15. Birthplace

Taylorville md

16. Informant

George W. Purnell

Address

Synagogue mdBerlinDate thereof June 24 1948
(month) (day) (year)

Cemetery or crematory

same as above

Location

Synagogue md

18. Funeral director

James H. Stuart

Address

Salisbury md

19. Date rec'd by registrar

June 2919 48

Registrar

Lothel Strong Taylor

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1948 at 5 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 21 1948 to June 24 1948and that I last saw him alive on June 24 1948Immediate cause of death Bartholomew's disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Bartholomew's disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

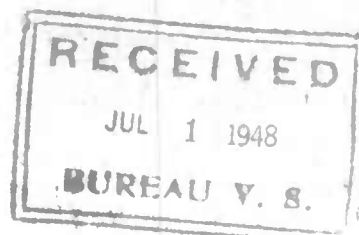
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE L. P. Grunne mdAddress Salisbury mdDate signed 6/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The total age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6637

Reg. Dist. No. X 336

1. PLACE OF DEATH

County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
108 Pine Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 Pine St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Saura Adeline Pusy

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Chas. F. Pusy
7. Birth date of deceased (mo., day, yr.) May 9 - 1883
6.(c) If alive, give age 67 years
8. AGE: Years 65 Months 5 Days 1 If less than one day
hrs. min.9. Birthplace Somerset County, Md.
Town, county, and state10. Usual occupation House work11. Industry or business House12. Name Allison Thomas Pusy13. Birthplace Somerset Co. Md.14. Maiden name Elyshth Burns15. Birthplace Somerset Co. Md.16. Informant Chas. F. PusyAddress Delmar, Del.17. Burial Date thereof 7-3-48
(Burial) Which? (month) (day) (year)Cemetery St. Olives CatholicLocation Delmar, Del.18. Funeral director H. S. Brown Co.Address Delmar, Del.19. July 3rd 1948 Registrar Harry E. Hudson

(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1948 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 1946 to June 30 1948and that I last saw him live on June 30 1948Immediate cause of death acute cardiacdilatation

DURATION

6 hoursDue to Chronic Hypertensive CardiacdegenerationDue to Chronic nephritis10 yrs2 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Byrd M. D. or otherAddress Delmar, Del. Date signed July 2/48

RECEIVED

JUL 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6638

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:
P.B. HoptHow long in hospital or institution? 1 day

3. (a) FULL NAME

Mary E. Rathgeber

3. (b) Social Security Number

4. Sex

female

5. Color or race

White

6. (c) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Fredrick John Rathgeber6. (c) If alive, give age 63 years

7. Birth date of

deceased (mo., day, yr.)

May 13 - 1886

8. AGE:

Years

Months

Days

It less than one day

62018

hrs.

min.

9. Birthplace

Panama City, Rhode Island
(Town, county, and state)

10. Usual occupation

John wife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?)

Date thereof

(month, day, year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 6-3-4819. 6-3-4819. 6-3-4819. 6-3-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 1st19. 48at 8:50 a.m.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2819. 48to June 119. 48

and that I last saw him alive on

June 119. 48

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

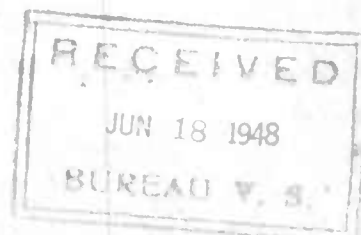
M. D. or other

Address

238

Date signed

6-3-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6639

Reg. Dist. No. 332

1. PLACE OF DEATH:

County... Wicomico
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... New York County...
 City or town... New York (Brooklyn)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hotel Parkside, Gramercy Park
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Miss
Seoville, Miss Elizabeth

3. (b) Social Security Number

4. Sex Female 5. Color of race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) May 14, 1866
 8. AGE: Year 82 Months 1 Days 4 If less than one day
hrs. min.

9. Birthplace... New York State
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... Frederick Seoville
 13. Birthplace... New York
 14. Maiden name... Sarah Bremner
 15. Birthplace... New York

16. Informant... Mrs. Virginia Nicole
 Address... 118 Lake Road Drive Salisbury Md

17. Buried Date thereof... June 21, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Greenwood Cemetery
 Location... New York

18. Funeral director... James A. Burbage
 Address... Burke Ave.

19. June 15, 1948 Louise Strong Taylor
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 18, 1948 at 12:00
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 17, 1948 to June 18, 1948
 and that I last saw her alive on June 18, 1948
 Immediate cause of death... Respiratory failure
 Due to... Cerebral Vascular accident 4 days
 Due to... Hypertension 5 yrs.
 Other conditions

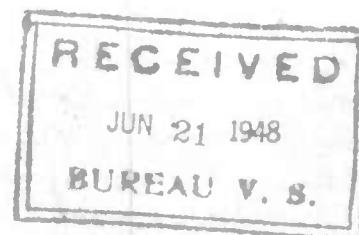
(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... Robert R. Starr
 Address... Salisbury Date signed... 6-18-48
 M. D. or other



RECEIVED

JUN 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6640

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 mo.
 Hospital, institution, or street address where death occurred:
Canaan Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Wicomico
 City or town Salisbury, MD
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Canaan Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lena Margaret Smith

3. (b) Social Security Number

4. Sex mf 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Harmon E. Smith
 7. Birth date of deceased (mo., day, yr.) August 27, 1872 6. (c) If alive, give age _____ years
 8. AGE: Years 75 Months 9 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Stroaca, New York
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thalia S. Jarvis
 13. Birthplace Stroaca, New York

MOTHER 14. Maiden name Juliana Carlton
 15. Birthplace Orvia Ontario

16. Informant Mrs. Lee Allen
 Address Salisbury, MD

17. Buried Date thereof 6/3/48
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Pleasant Grove

Location Orville, New York

18. Funeral director The Well & Howard Co

Address Salisbury, MD

19. 6/1, 1948 Harriet E. Johnson Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1948 at 3:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1948 to June 1 1948

and that I last saw her alive on May 31 1948

Immediate cause of death _____ DURATION _____

Carcinoma of liver

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lucas D. Francis, M.D. M. D. or other _____
 Address Salisbury, MD Date signed 6/1/48

RECEIVED

JUN 18 1948

BUREAU V. S.

Dr. Rademacher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6641

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County SalisburyCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Ne. CornicCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. Glenn St.
(If rural, give LOCATION)2. (c) If veteran, name war World War #1

3. (a) FULL NAME

Norma Pilchard Smith

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Buttuh Margaret Smith

7. Birth date of deceased (mo., day, yr.)

Nov. 15, 1913

6. (c) If alive, give age

29 years

8. AGE:

Years 34 Months 6 Days 19 If less than one day
hrs. min.

9. Birthplace

Salisbury Md.
(Town, county and state)

10. Usual occupation

John B. Wilghman Factory

11. Industry or business

John B. Smith

12. Name

Salisbury Md.

13. Birthplace

John B. Wilghman

14. Maiden name

Salisbury Md.

15. Birthplace

Buttuh M. Smith

16. Informant

Glenn St. Salisbury Md.

17. Burial

June 7-48

18. Cemetery or crematory

Pharmacia Cem.

19. Location

Salisbury Md.

20. Funeral director

Holloman & Co. Walter R. Holloman

21. Address

Salisbury Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1948 11:10 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

medically and that I last saw him alive on June 4 1948Immediate cause of death Crushed ChestDue to Crushed ChestDue to Crushed ChestOther conditions Crushed Chest

(Include pregnancy within 8 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-4-48Where did injury occur? Salisbury (County) Ne. Cornic (State) Md.Injured at home, farm, industry, public place (where?) Farther FactoryMeans of injury Crushed by host Injured at work? Yes23. SIGNATURE Dr. Rademacher MDAddress Salisbury Md. Date signed 6/5/4819. 6/7 1948

(Date reg'd by registrar)

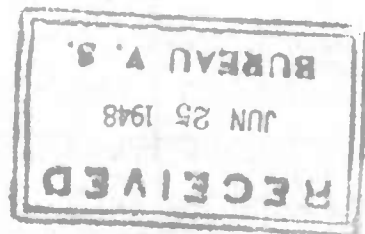
Registrar

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 983

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
Peninsula Hm. Hosp.
 How long in hospital or institution? 9 days 19 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Pocomoke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Snead, Ardella

3. (b) Social Security Number

4. Sex Female 5. Color or race col. 6.(a) Single, married, widowed, or divorced Separated
 6.(b) Name of husband or wife Edward Snead
 7. Birth date of deceased (mo., day, yr.) December 4, 1909 6.(c) If alive, give age _____ years
 8. AGE: Years 38 Months 6 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Accomac, Virginia
 (Town, county, and state)
 10. Usual occupation Domestic
 11. Industry or business _____
 12. Name Frank Young
 13. Birthplace Accomac, Virginia
 14. Maiden name Estelle White
 15. Birthplace Accomac, Virginia
 16. Informant Margaret Kelson
 Address Pocomoke, Maryland
 17. Burial Date thereof June 8, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Metomple
 Location Metomple, Virginia
 18. Funeral director J. Edgar Thomas
 Address P.O. Box 243, Accomac, Va
 19. 6/10, 1948 Registrar Barriett L. Johnson
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

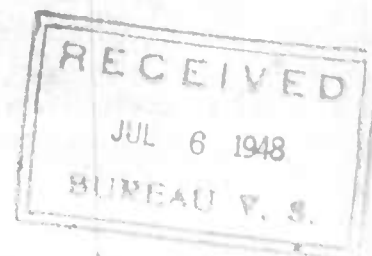
20. DATE OF DEATH June 5, 1948 at 5:40 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/26 1948 to June 5 1948 and that I last saw her alive on June 5 1948.
 Immediate cause of death Voluntary Intoxication DURATION u/s
 Due to _____
 Due to _____
 Other conditions Internal Failure u/s
 (Include pregnancy within 3 months of death)
 Major findings of operations Internal Failure Date of op. 5/27/48
 Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE

J. Edgar Thomas M. D. or other _____
 Address Pocomoke Date signed 6/7/48



RECEIVED

JUN 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico Co.
City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 4 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Stiles

3. (b) Social Security Number

4. Sex female 5. Color or race col. 6.(a) Single, married, widowed, or divorced married.

6.(b) Name of husband or wife See Stiles

7. Birth date of deceased (mo., day, yr.) 1897. 6.(c) If alive, give age _____ years

8. AGE: Years 51 Months - Days - If less than one day _____ hrs. _____ min.

9. Birthplace Quantico Md.
(Town, county, and state)

10. Usual occupation homestic.

11. Industry or business none.

12. Name See Prior

13. Birthplace Quantico Md.

14. Maiden name Mintie Jones

15. Birthplace Quantico Md.

16. Informant Medline Mitter.

Address Salisbury Md.

17. Burial Burial Date thereof June 27-1948.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Nesby Creek Md.

18. Funeral director Baker M. West

Address Salisbury Md.

19. 6-26-48 19 48 Barrett E. Johnson
(Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 48 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 48 to June 23 19 48

and that I last saw him alive on June 23 19 48

Immediate cause of death Coronary thrombosis

Due to Arteriosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E.A. Purnell, M.D. M. D. or other _____

Address 800 W. Main St. Date signed 6-26-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 30 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

6645

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Mr Pittsville md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Edward Truitt

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Ellen Truitt

7. Birth date of

deceased (mo., day, yr.)

Dec 6 19236. (c) If alive, give age 19 years

8. AGE:

Years

Months

Days

If less than one day

2264

hrs.

min.

9. Birthplace

Near Willards Md
(Town, county, and state)

10. Usual occupation

farm labor

11. Industry or business

FATHER

12. Name

Jennet Truitt

13. Birthplace

Willards Md

14. Maiden name

Effie Edna Dickerson

15. Birthplace

Delaware

16. Informant

Jennet Truitt

Address

Willards Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

June 12, 1948
(month) (day) (year)

Cemetery or crematory

New Hope

Location

Near Willards Md

18. Funeral director

Wm. Howard Wells

Address

Pittsville, Md

19.

(Date recd by registrar)

6/10/48

19.

48

1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

Wicomico

City or town

Pittsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 10th 1948 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner Certificate
and that I last saw him June 10, 1948 alive on June 10, 1948

Immediate cause of death

Gunshot wound of head

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 6/10/48Where did injury occur? Pittsville, Wicomico, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Shot by wife Injured at work? no.

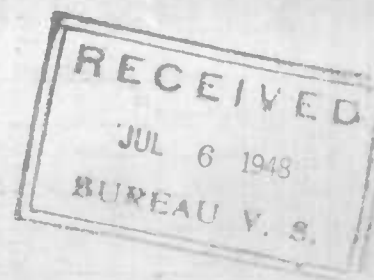
23. SIGNATURE

Clara Truitt 2000Address Pittsville, Md Date signed 6/10/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula Gen. Hosp.
How long in hospital or institution? 20 days, 22 hrs, 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 900 Lake St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mackey, Lillian

3. (b) Social Security Number

4. Sex

female

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Reed

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

43

hrs.

min.

9. Birthplace

Wicomico Co., Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Same as above

FATHER

12. Name

John Addins

13. Birthplace

near Salisbury, Md.

MOTHER

14. Maiden name

Bella Shockley

15. Birthplace

near Salisbury, Maryland

16. Informant

Mrs. Elizabeth Hopkins

Address

900 Lake St. Salisbury Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6-20-48
(month) (day) (year)

Cemetery or crematory

Green Acres

Location

Salisbury, Maryland

18. Funeral director

James F. Stewart

Address

402 E. Church St. Salisbury, Md.19. 6/18/48

(Date read by registrar)

Barbara F. Johnson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 48 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 19 48 to June 15 19 48
and that I last saw her alive on June 15 19 48

Immediate cause of death

hemorrhage (vaginal)

DURATION

sudden

Due to

coronary artery thrombosis

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following: No

Accident, suicide, or homicide..... Date of.....

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

La Rodemacher M.D.
Address Salisbury Md. Date signed 6/18/48

RECEIVED

JUN 30 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 233

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

19. Funeral director

Address

19.

(Date rec'd by registrar)

19.

19.

Walter G. Mann

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 15 1948 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 1948 to June 15 1948

and that I last saw him alive on

June 15 1948

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other conditions

Deafness

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JUN 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 993

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 months
 Hospital, institution, or street address where death occurred:
Dania St. -
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Somerset
 City or town Westover
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ☒

3. (a) FULL NAME

Emma Frances Warren

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Albert Warren
 7. Birth date of deceased (mo., day, yr.) April 17, 1867 6. (c) If alive, give age _____ years
 8. AGE: Years 81 Months 2 Days 1 If less than one day _____ hrs. _____ min.
 9. Birthplace Somerset County - Md
 (Town, county, and state)
 10. Usual occupation House wife

11. Industry or business

12. Name John Webb
 13. Birthplace Somerset County Md
 14. Maiden name Mary Emily Cottman
 15. Birthplace Somerset County Md
 16. Informant Mrs. Florence Smith
 Address Hospital, Salisbury Md
 17. (Burial, cremation, or other disposal, Which?) Burial Date thereof June 20, 1948
 (month) (day) (year)
 Cemetery or crematory St. Mary's Episcopal Cemetery
 Location Pocomoke City, Md
 18. Funeral director John A. Bradshaw
 Address Pocomoke City, Md

19. 6/18/48 19 48 W. A. Bradshaw Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 19 48 at 8:30 am
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 19 48 to 6-18 19 48
 and that I last saw her alive on 6-17-48
 Immediate cause of death Cardio-vascular renal disease
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Paula L. Lush M. D. or other MD
 Address Salisbury Md Date signed 6-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6648

131a

RECEIVED

JUN 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County MicomicusCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula Gen. Hosp.

How long in hospital or institution?

4 days 10 days 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MicomicusCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 233 South Main St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Williams, Mr. Charles

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife

Grace Yukie Williams

7. Birth date of deceased (mo., day, yr.)

April - 8 - 1906

6. (c) If alive, give age

31 years

8. AGE:

Years 42Months 2Days 15

If less than one day

hrs. min.

9. Birthplace

not known Md.

(Town, county, and state)

10. Usual occupation

Salisbury

11. Industry or business

FATHER

12. Name

Strawther William

13. Birthplace

Samuel G. Md.

MOTHER

14. Maiden name

Nona Jenkins

15. Birthplace

York Md.

16. Informant

Mr. Grace Y. Williams

Address

423, Dilgman St. Salisbury Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

June 26 48

Cemetery or crematory

Parson's Cem.

Location

Salisbury Md.

18. Funeral director

Hollingsworth, G. Walter H. Hollingsworth

Address

Salisbury Md.

19. (Date rec'd by registrar)

6-25-48

19. 48

6-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-486-25-48

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1948 at 5:38 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 1948 to June 23 1948and that I last saw him alive on June 23 1948

Immediate cause of death

Respiratory failure

Due to

Lobar Pneumonia

Due to

5 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE

R. R. Starr

M. D. or other

Address

Salisbury

Date signed

6-25-48

RECEIVED

JUN 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury Oldjersey Road
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 wks
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth M. Wilson

3. (b) Social Security Number

4. Sex Female 5. Color or race Cal 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife none
 7. Birth date of deceased (mo., day, yr.) 1886
 8. AGE: Years 62 Months 4 Days — If less than one day _____ hrs. _____ min.

9. Birthplace Tyaskin Md.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business None

12. Name Samuel Wilson

13. Birthplace Tyaskin Md.

14. Maiden name Ernie Johnson

15. Birthplace Tyaskin Md.

16. Informant Mrs. Nettie Peters

Address gasey Road.

17. Burial Date thereof July 2 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Head Creek Cem

Location Head Creek Rd.

18. Funeral director Becker M. West

Address Salisbury Md.

19. 7/3 19 48 Carrie L. Johnson Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20th 19 48 at 1054 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 22 19 48 to June 29 19 48
 and that I last saw him or alive on June 28 19 48

Immediate cause of death Cerebral hemorrhage DURATION 1 day

Due to arteriosclerosis ?

Due to _____

Other conditions Diabetes mellitus ?

Securitis with gangrene ?
 (Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature G. V. Bohler, M.D. M.D. or other _____

Address Delmar, Del Date signed July 1/48

RECEIVED

JUL 13 1948

BUREAU V. S.

Dr. Lonkford

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6651

CERTIFICATE OF DEATH

170C

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula Gen Hosp.
How long in hospital or institution? D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ☒

3. (a) FULL NAME
Wilson, Joshua

3. (b) Social Security Number

4. Sex: male
5. Color or race: col.
6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.): August 20, 1885

8. AGE: Years: 62 Months: 10 Days: 17
If less than one day: hrs. min.

9. Birthplace: Princess Anne, Md.
(Town, county, and state)

10. Usual occupation: h and scape gardener

11. Industry or business

12. Name: Joshua Wilson

13. Birthplace: Princess Anne, Md.

14. Maiden name: Hemette Britton

15. Birthplace: Princess Anne, Md.

16. Informant: Rose Wilson

Address: Princess Anne, Md.

17. Burial, cremation, or removal, Which?: Burial
Date thereof: 6-10-1948
(month) (day) (year)

Cemetery or crematory: John Wesley

Location: Princess Anne, Md.

18. Funeral director: William H. James Jr

Address: Princess Anne, Md.

19. 6/8, 19 48, Harriet L. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 1948 at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

to that I last saw him alive on

Immediate cause of death: Broken neck, fractured skull & other serious injuries

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident
Accident, suicide, or homicide Date of: 6/6/48

Where did injury occur: Princess Anne, Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Public place

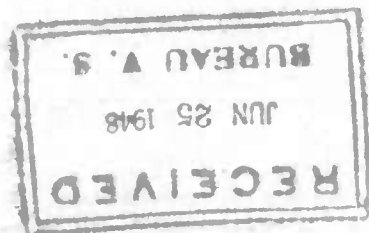
Means of injury: Auto accident Injured at work? No

23. SIGNATURE: Wm. M. Sanford M.D.
Address: Princess Anne, Md Date signed: 6/7/48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 399

1. PLACE OF DEATH:

County Wilcomico
 City or town Salisbury R.R.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Two weeks
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Wilcomico
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Lattie Wilson

3. (b) Social Security Number

Last

4. Sex female 5. Color or race A.A. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Maurice Wilson

7. Birth date of deceased (mo., day, yr.) yes 6. (c) If alive, give age Don't know years

8. AGE: Years 64 Months - Days - If less than one day _____ hrs. _____ min.

9. Birthplace Domes Quarter md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Thomas Burtis

13. Birthplace Domes Quarter Md

14. Maiden name Hannah Jones

15. Birthplace Domes Quarter

16. Informant Maurice Wilson

Address Domes Quarter

17. Burial Burial Date thereof June 29, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Domes Quarter

Location Domes Quarter Md

18. Funeral director James Stewart

Address Salisbury Md

19. 6/29 19. 48 Robert J. Stewart
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 19. 48 at 2⁰⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19. 48 to June 27 19. 48

and that I last saw him alive on June 27 19. 48

Immediate cause of death Cerebral

Thrombosis

Due to Arteriosclerosis

Due to _____

Other conditions _____

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. Russell M.D.

Address 800 Wman St M.D. or other _____
 Date signed 6-29-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6652

838

RECEIVED

JUL 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

106 Parsons St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 106 Parsons St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elijah Winfield Windsor

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Filly F. Windsor7. Birth date of deceased (mo., day, yr.) Sept 26, 1866 6.(c) If alive, give age 81 years8. AGE: Years 81 Months 8 Days 29 / If less than one day9. Birthplace Salisbury, Wicomico, MD
(Town, county, and state)10. Usual occupation Cabinet Maker

11. Industry or business

12. Name Wilham Edna Windsor13. Birthplace Salisbury MD14. Maiden name Phoebe Washburn15. Birthplace Salisbury, MD16. Informant Miss Edna WindsorAddress Salisbury MD17. (Burial, cremation, or removal, Which?) Burial Date thereof 6/28/48
(month) (day) (year)Cemetery or crematory ParsonsLocation Salisbury, MD18. Funeral director Wm. Hill & Johnson CoAddress Salisbury MD19. Date rec'd by registrar June 26, 1948 Registrar Lois E. Strong Taylor

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1948 at 6 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 19 45 to June 25, 1948and that I last saw him alive on June 24, 1948Immediate cause of death Congenital Heart FailureDue to Chronic Arterio Sclerotic Heart Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

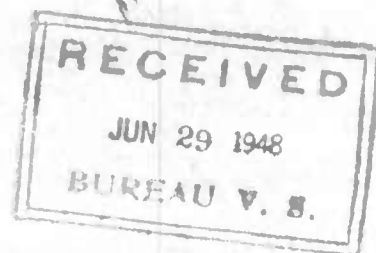
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lucas P. Grance MD M. D. or other Salisbury, MD Date signed 6/25/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6654

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

229 E. Pinchum Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 229 E. Pinchum Ave.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Joan Mae Wingate

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

S.

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 2nd 1946

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

2228

hrs.

min.

9. Birthplace

Salisbury Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

18

48

Louise Strong Taylor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 30th 1948 at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1946 to June 30 1948
and that I last saw her alive on June 29 1948

Immediate cause of death

Congenital heart disease
(defect in ventric. septum) 2 years

Due to

Due to

Other conditions

Gastroenteritis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address

Delmar, Del.

Date signed

7-1-48

